

**THE COMPARATIVE  
MANAGED CARE CASE STUDY  
QUESTIONNAIRE**

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**Submitted by the *ZdravReform* Program to:**

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with Offices in: Bethesda, Maryland, U.S.A.  
Moscow, Russia; Almaty, Kazakhstan; Kiev, Ukraine**

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### ***THE COMPARATIVE MANAGED CARE CASE STUDY: ORGANIZATIONAL OUTLINE***

Over two years of operation primarily in Russia, Kazakhstan, Kyrgyzstan, Ukraine, and Moldova the *ZdravReform* Program has implemented a variety of technical assistance, training, and grant-related activities that may be classified as managed care within NIS health care systems. This is an opportune time for all of us in *ZdravReform* to evaluate the outcomes from such work, thus making our experiences and lessons learnt available for the NIS counterparts as well as the larger international community of donor and recipient organizations.

Successes and failures are of equal value to us in the context of this study. Therefore, we encourage our respondents to remain unbiased in their assessments and reports. A meaningful approach would be to reveal the nature of positive as well as negative outcomes by making an accurate inventory of both and determining what factors inherent

in the modern NIS health sectors worked to facilitate or hinder the *ZdravReform* innovative effort.

The Case Study is intended to become a Program-wide team effort, with key inputs expected from the regional and field offices as well as from technical contributors -- both expatriate and NIS-based. Heads of the regional offices are invited to take the lead in planning and coordinating this work on a site-specific level. Headquarters staff will coordinate with field staff to determine who will collect the data in each case identified. The following sites were originally identified as managed care pilots: "Phosphorus" HMO in Shymkent, the Family Health Center in Odessa, the Tula-Albany Insurance Company managed care plan, the Kedrov and Tyssul Rayons managed care networks in Kemerovo Oblast. If more pilots are known, e.g. in Karakol Oblast, Kyrgystan, the rural health care of Moldova, and health facilities in Central Russia, implementers are invited to provide a concise description of respective cases, emphasizing the managed care features in their concepts, design and/or operations. Newly identified cases will then be integrated into the planned study.

The time line of the study requires that inputs from the field should be completed by April 15th. Interim deadlines will be specified soon.

Please, refer your suggestions and remarks relating to the technical and organizational aspects of the *Comparative Managed Care Case Study* to Alexander Telyukov at: 301-913-0544 (phone), 301-913-0562 (fax), sasha\_telyukov@abtassoc.com (internet). Essential information should be copied to N.Pielemeier, M.Makinen, R.Killian, J.Novak, L.Moll, S.Tumanova (project assistant) and respective regional back-stops. For translation and distribution of the following Questionnaire and other Study materials, please, contact Courtney Roberts.

## ***INTRODUCTION TO THE QUESTIONNAIRE***

The purpose of this Questionnaire is to assemble a standardized set of statistical and descriptive information that would facilitate comparative evaluation of managed care pilot experiments, conducted by the *ZdravReform* Program.

The Questionnaire is designed as a data collection and interview guide to be used in a research investigation and focus group types of activities. The instrument is targeted at a variety of audiences, i.e. representing (1) health system regulators, (2) payers, (3) health management at the facility level, (4) physicians and health professionals, (5) consumers of care, (6) consultants and trainers. Certain modules of the Questionnaire are clearly distinct in terms of who the respondents should be.

It is our strong recommendation that the researchers and focus group leaders, operating in the same area and referring their questions to the experiences with the same managed care pilot site, should become familiar with the entire questionnaire before applying the Questionnaire in interview with respondents. A good way to reach such alignment may be

to hold an internal discussion as to the meaning of the questions, then simulate the answers to see how well they match the questions, and finally, conduct evaluation of the Questionnaire at large to see if it captures the peculiarities of the local experiences of developing a managed care plan. On-going coordination and discussions will be helpful to check if there are significant and/or persistent misreadings of the questions or deviations from the Questionnaire.

Necessary adjustments will be easy to make by mapping additional information into the open line-items or as a separate custom-tailored module to the originally proposed Questionnaire. Narrative is always welcome to disclose and complement the answers. While expanding the Questionnaire outline as appropriate for the needs of a specific case study, please do not ignore the originally proposed standard list of questions and multiple-choice answers. If the questions are not applicable or irrelevant, please indicate so. This would allow us to fulfill the primary goal of this Questionnaire: use it as an instrument for a *comparative* case study of managed care plans that were conceived, designed and developed with the assistance from *ZdravReform*.

Prior to the focus group exercise, please circulate a pre-formatted attendance list to the participants so that they can indicate their names, profession by training, occupation, total number of years in professional career, current position, number of years in health-related field, address and telephone numbers. The date, place and duration of the focus group sessions or individual interviews should be specified as well.

Please complete this Questionnaire through as many focus group sessions and individual interviews as you deem necessary to insure a representative sample. However, since the time frame and resources to conduct the study are constrained it is advisable to emphasize the quality of the focus groups and data collection exercises rather than their number. Therefore, the most competent, well informed and outspoken should be approached or invited to participate in the focus groups, and the most reliable and comprehensive source of statistics should be utilized.

Please feel free, where appropriate, to arrange statistical data, responses and narrative in tables and annexes. It is important, however, that regardless of the presentation format ordinal numbers of the line items are strictly observed.

Completed questionnaires should be submitted to the *ZdravReform*/ Bethesda Office by March 20th, 1996. A one-page progress report should be presented by March 1st. Substantive remarks, suggestions and discussions will be welcome at any time.

## **QUESTIONS AND MULTIPLE-CHOICE ANSWERS**

### **1 CASE DEFINITION**

- 1.1 Which projects, experiments, or demonstrations within your scope of technical assistance or management oversight work would you identify as related to the design, development, implementation, and/or operation of a managed care plan? Please provide a one paragraph description, specifying location, name and type of institution(s) involved, goal and objectives driving the innovation, essence of the innovation. Use managed care language and taxonomies practiced in the United States. Also, please define the case in terms proposed and accepted by the NIS counterparts.

### **2 CASE HISTORY AND KEY PLAYERS**

*Items 2.1-2.5: If more than one, please estimate a line-item share in percent of the total.*

- 2.1 Who/what initiated the innovation?
- 2.1.1 Legal action on the federal (national) level
  - 2.1.2 Legal action on the local level
  - 2.1.3 Initiative by local institution(s)
  - 2.1.4 Initiative by a local individual or group of individuals
  - 2.1.5 Domestic or international consultant(s)
- 2.2 What type of institutions do the innovation proponents represent?
- 2.2.1 Government(s)
  - 2.2.2 Health regulatory agencies
  - 2.2.3 Payer(s): Health Department, TMHIF, private insurance carriers
  - 2.2.4 Group plan subscribers: employers, consumer alliances
  - 2.2.5 Individual subscribers: the insured, patients
  - 2.2.6 Political parties, labor unions
  - 2.2.7 Community, grassroots organizations
  - 2.2.8 Business consultancies
  - 2.2.9 International investors
  - 2.2.10 International donor institutions
- 2.3 What triggered the thinking/idea?
- 2.3.1 Regulatory pressure
  - 2.3.2 Academic knowledge: basic education, professional reading, research
  - 2.3.3 Continuing training: domestic
  - 2.3.4 Professional exchange: domestic
  - 2.3.5 Technical assistance by consultants: domestic
  - 2.3.6 International travel and professional exchange: internships, conferences,
    - 2.3.6.1 observation and training tours, printed materials

2.3.7 International on-site technical assistance

2.3.8 Personal creativity and inventiveness

2.4 Where do the prototype concepts and ideas come from?

2.4.1 Domestic experiences: local, regional, national

2.4.2 NIS experiences

2.4.3 European experiences

2.4.4 US experiences

2.4.5 Other

2.4.6 Combination of the above listed (please, specify)

2.5 At what stage of implementation is this case? Please, provide a brief narrative in order to summarize and, perhaps, expand the information of this module.

### 3 CASE BACKGROUND: SOCIO-ECONOMIC ENVIRONMENT

3.1 What are the main issues of policy concern in the local area (oblast, city, rayon) viewed by specific institutions, professional and interest groups? Choose from

(5)-

very important; (4)-fairly important; (3)-unimportant; (2)-totally irrelevant; (1)-

not

sure

	Government officials	Health Administrators	Provider community	Public (consumers)	Political opposition	The media	In aggregate
Decline in production and lack of investment capital							
Job/income insecurity							
Poverty/lack of safety nets							
Disintegration of social services							
Health							
Other (please, specify)							

3.2 What are the predominant attitudes towards political and economic liberalization on the part of specific institutions, professional and interest groups [please choose from (5) “strong support” - (4) “apparent support, yet little consistency in practice” - (3) “hidden opposition” - (2) “aggressive opposition” - (1) “not sure”]

- 3.2.1 Government officials
- 3.2.2 Health sector administrators
- 3.2.3 Health service provider community
- 3.2.4 The public (consumers)
- 3.2.5 Political opposition
- 3.2.6 The media
- 3.2.7 In aggregate

3.3 How sustainable is the local economy relative to the national, regional, and territory per capita averages? Please arrange numbers in a statistical table indicating per capita values for the nation, region, and local administrative unit; and also regional and local per capita in percent to the national.

- 3.3.1 GDP or Net Material Product
- 3.3.2 Local budget outlays as compared to contiguous territories
- 3.3.3 Payroll
- 3.3.4 Personal income (Wages and salaries)
- 3.3.5 Unemployment rate
- 3.3.6 Businesses operating on the negative margin
- 3.3.7 Privatized businesses: number and employment

3.4 What shaped your opinion on the above issues [a line-item share in percent of the total]?

- 3.4.1 Direct questions
- 3.4.2 Explanations by the counterparts provided on their own initiative
- 3.4.3 Academic publications and professional reports
- 3.4.4 The media
- 3.4.5 Other

3.5 Please provide a brief narrative on the issues covered in this section.

#### 4 **CASE BACKGROUND: HEALTH STATUS, POLICY, AND FINANCE**

4.1 What are the demographic and health trends in the local area? [10 years time series, plus 1970 and 1980 as benchmarks]:

- 4.1.1 Population number
- 4.1.2 Percent urban population
- 4.1.3 Percent retirees
- 4.1.4 Median or average family
- 4.1.5 Life expectancy: men

- 4.1.6 Life expectancy: women
  - 4.1.7 Birth rate
  - 4.1.8 Mortality rate
  - 4.1.9 Infant mortality
  - 4.1.10 Infectious disease incidence rate
  - 4.1.11 Other if relevant
- 4.2 What is the status of the local area in terms of access to health care resources:
- 4.2.1 Physicians per 10,000 population
  - 4.2.2 Health personnel per 10,000 population
  - 4.2.3 Adult hospital beds per 10,000 adult population
  - 4.2.4 Pediatric hospital beds per 10,000 children
  - 4.2.5 Adult polyclinics and other outpatient facilities, capacity in patient visits per work shift
  - 4.2.6 Pediatric polyclinics and other pediatric facilities, capacity in patient visits per work shift
- 4.3 What is the utilization profile of the local area:
- 4.3.1 Annual number of outpatient visits to a physician
  - 4.3.2 Hospital admission rate per 10,000 population
  - 4.3.3 Average length of stay: aggregate and by major clinical specialty
- 4.4 What are the health expenditure patterns in the local area:
- 4.4.1 Per capita health spending
  - 4.4.2 Health spending as percent of budget outlays
  - 4.4.3 Inpatient vs. outpatient
  - 4.4.4 Share of budget general revenue
  - 4.4.5 Share of mandatory health insurance, if in place
  - 4.4.6 Share of other sources (specify if possible)
- 4.5 Please, indicate essential features of provider reimbursement mechanisms.
- 4.5.1 Predominant methods of payment to the hospitals
  - 4.5.2 Predominant methods of payment to outpatient care providers
  - 4.5.3 Incentive-based alternatives: instances, scope of application, outcomes
- 4.6 What are the priorities on the health policy agenda, as viewed by the stakeholders? Rank order 1 to 5: (5) - very important; (4) - fairly important; (3) - unimportant; (2) - totally irrelevant; (1) - not sure.

<i>Issues</i>	<i>Legislature, Government</i>	<i>Health administration</i>	<i>MHI Fund</i>	<i>Hospital Chief Doctors</i>	<i>Polyclinic Chief Doctors</i>	<i>Physicians and health professionals</i>	<i>Employers</i>	<i>Consumers of care</i>
Maintain physical plant and personnel								
Maintain recurrent funding from long-established sources								
Maintain/improve quality of care								
Maintain access to resource inputs (drugs, medical supplies) through centralized procurement								
Create and/or operationalize mandatory health insurance								
Develop alternative methods of health financing, e.g. voluntary insurance, co-insurance, user charges								
Shed excessive capacity and shift resources across clinical specialties in hospitals and polyclinics								
Restructure polyclinics into independent physician practices								
Create new types of provider institutions								
Shift care outpatient								
Improve productivity								
Adjust the existing health administration and management mechanisms by supplementing them with economic incentives and competitive contracting								
Shift emphasis from plan- and-command to self-regulatory mechanisms in the health care system								
Unleash market forces in the health care sector by allowing competitive private health insurance and provision of services								
Recur to the company-based services								

- 4.7 Please give a concise one-paragraph narrative on the health status, policy, and finance environment in the pilot area.

## 5 PROVIDER ATTITUDES

- 5.1 Which of the following statements describe best the current professional concerns among the physician community and doctors' own definitions of the main impediments to their work? Please estimate using the following scale: (6) strongly agree - (5) somewhat agree - (4) rather disagree - (3) strongly disagree - (2) irrelevant - (1) not sure?
- 5.1.1 Shortage of pharmaceuticals and medical supplies.
  - 5.1.2 Poor technologies and/or lack of modern equipment.
  - 5.1.3 Low salaries.
  - 5.1.4 Lack of reward for high skills and performance.
  - 5.1.5 Excessive work load and hours.
  - 5.1.6 Lack of job security.
  - 5.1.7 Lack of clinical guidelines.
  - 5.1.8 Clinical guidelines are excessive and/or inconsistent.
  - 5.1.9 Lack of collegiality in clinical decision-making.
  - 5.1.10 Lack of continuity in the provision of health services within and/or across medical facility(ies).
  - 5.1.11 Primary care does not do well its job of preventing and detecting disease at an early stage, and follow-up.
  - 5.1.12 Outpatient specialists could do more and better.
  - 5.1.13 Outpatient diagnostics does not improve efficiency for the hospital.
  - 5.1.14 Hospitals discharge patients too early or otherwise under-perform their functions, thus increasing pressure on outpatient facilities.
  - 5.1.15 Lack of support from nursing and other medical personnel.
  - 5.1.16 Lack of support from clerical personnel.
  - 5.1.17 Excessive paperwork.
  - 5.1.18 Professionally uninspiring setting: lack of opportunity for continuing education.
  - 5.1.19 Patients are prone to over-utilization of services.
  - 5.1.20 Patients tend to ignore doctor's prescriptions, advice, and guidance.
  - 5.1.21 Patients have become more demanding and inclined to critical scrutiny of doctors' decisions and performance.
  - 5.1.22 The health delivery system is good for provider of care and should be maintained in its traditional form; a few specific adjustments are desirable [please, specify].
  - 5.1.23 Other [please, specify]

## 6 CONSUMER ATTITUDES

- 6.1 Which of the following statements match consumer concerns regarding accessibility and quality of care? Please estimate using the following scale: (6) strongly agree - (5) somewhat agree - (4) rather disagree - (3) strongly disagree - (2) irrelevant - (1) not sure.
- 6.1.1 Services are easy to access and of high quality; the health care system should be maintained with minor adjustments only [please, specify].
  - 6.1.2 We have no choice of a doctor and a hospital, which, we feel, negatively affects doctors' attitudes and quality of care.
  - 6.1.3 We know, doctors have their own troubles, yet feel we cannot pay for medical services as much as they expect us to do.
  - 6.1.4 Mandatory health insurance did not bring much change, not at least that we consumers can see.
  - 6.1.5 There is a lack of continuity of care among medical facilities.
  - 6.1.6 Doctors are not attentive to our needs and complaints, unable to listen or explain things.
  - 6.1.7 Paid care is acceptable for us if it is of a better quality, and bears more sense of responsibility, and if fees are officially established and payment procedures clearly defined.
  - 6.1.8 Information is so scarce that we do not know how to shop for better care even if we would like to pay for it.
  - 6.1.9 We would like health insurance to be more personal, focused on our needs, rather than dealing with big masses of people, such as population of the entire oblast. We want to know who our insurers are and where doctors are waiting to attend to our health problems.
  - 6.1.10 We would like for health insurance to cover us on a family basis, even if we are required to co-pay for such coverage.
  - 6.1.11 We will welcome more choice in shaping packages of services intended for health insurance coverage.
  - 6.1.12 Other [please, specify].

## 7 **PROGRESS IN THE MANAGED CARE PLAN DEVELOPMENT AND IMPLEMENTATION**

- 7.1 Please evaluate the degree of progress along specific lines of the managed care (MC) Plan development and implementation using the following point scale: (1) not perceived as essential; (2) considered yet remained largely unaddressed; (3) included in original plans and outline, yet not developed; (4) developed conceptually and schematically, yet not as a blueprint; (5) operationalized on paper, yet not implemented; (6) implementation is underway; (7) implementation is in a pre-ribbon-cutting stage [please indicate projected roll-out dates]; (8) validated; (9) existed prior to *ZdravReform* Program:
- 7.1.1 Legal and contractual framework
  - 7.1.2 Internal management rules and procedures
  - 7.1.3 Clinical plan, including QA
  - 7.1.4 Budget and business plan

- 7.1.5 Management information support
- 7.1.6 Marketing and public relations

## 8 THE TYPE AND CONFIGURATION OF THE MANAGED CARE PLAN

8.1 What kind of an MC model was chosen for replication or approximation?  
Please, use brief narrative to describe the model chosen.

8.1.1 By basic organizational structure:

- 8.1.1.1 HMO: hospital-based
- 8.1.1.2 HMO: polyclinic-based
- 8.1.1.3 HMO: anchored in a free-standing physician practice
- 8.1.1.4 HMO: anchored in a specialized health center
- 8.1.1.5 Network HMO
- 8.1.1.6 PPO type
- 8.1.1.7 Other [please, define]

8.1.2 By scope of functional integration:

- 8.1.2.1 With financial component (integration of underwriting and service delivery)
- 8.1.2.2 Without financial component (provision of services only)

8.1.3 By scope of legal integration:

- 8.1.3.1 Fully integrated plan: operates as a single legal entity, e.g. property rights ceded to the MC Plan; with common mission and integrated management system, business plan, clinical guidelines, utilization targets and quality assurance standards, accounting and financial reporting
- 8.1.3.2 Partially integrated plan: legal alignment of autonomous providers, bound by contractual commitment to certain business, financial, utilization, and clinical targets, rules, and procedures; operating centralized marketing, procurement, and/or other selected departments and services; yet with separate property rights, management, reporting.
- 8.1.3.3 Business partnerships (associations) based on referral agreements

8.1.3.4 Other [please, describe]

8.1.4 By type of enrollment:

- 8.1.4.1 Voluntary enrollment (open to anyone)
- 8.1.4.2 Mixed enrollment (open to designated populations)

- 8.1.4.3 Assigned enrollment (e.g., restricted to an established catchment area)
- 8.1.4.4 Other (please, describe)

8.1.5 By coverage:

- 8.1.5.1 All services
- 8.1.5.2 All services within MHI coverage
- 8.1.5.3 Customized packages of services [please, specify]
- 8.1.5.4 Other [please, specify]

8.2 How is the referral network of the MC Plan staffed with providers?

- 8.2.1 Open bid [all providers of care were invited to compete for the contracts with the MC Plan]
- 8.2.2 Closed bid [targeted at preselected providers]
- 8.2.3 Non-competitive selection based predominantly on:
  - 8.2.3.1 Personal preferences of the plan's founders/top managers
  - 8.2.3.2 Quality considerations
  - 8.2.3.3 Cost considerations
  - 8.2.3.4 Designated by payer
  - 8.2.3.5 Designated by regulatory center
  - 8.2.3.6 Other [please, specify]

8.3 Please, list all affiliated institutions by type of provider. Underline institutions for whom participation in the MC Plan gives all or most of its business.

- 8.3.1 Prime fund-holder (general contractor with the payer)
- 8.3.2 Outpatient care
- 8.3.3 Hospital services
- 8.3.4 Maternity care
- 8.3.5 Other

## 9 FINANCIAL PROFILE OF THE MC PLAN

9.1 Who are the payers to the MC Plan [please indicate rough proportions]?

- 9.1.1 Health Administration of the territory
- 9.1.2 Local health authorities
- 9.1.3 MHI Fund
- 9.1.4 Insurance companies, operating under MHI
- 9.1.5 Voluntary health insurance carriers
- 9.1.6 Employers
- 9.1.7 Individuals
- 9.1.8 Other [please, specify]

9.2 What are the methods of payment to the MC Plan?

- 9.2.1 Reimbursement directly to each participating provider under one of the following arrangements [please indicate payers (if differs by payer), providers and/or types of services]:
  - 9.2.1.1 Comprehensive capitation rate
  - 9.2.1.2 Partial capitation rate
  - 9.2.1.3 Global budget
  - 9.2.1.4 Per patient discharge:
    - 9.2.1.4.1 Specialty average rates
    - 9.2.1.4.2 Broadly defined case-mix categories
    - 9.2.1.4.3 DRG-type case groups and rates
    - 9.2.1.4.4 Combination of the above [please, specify]
    - 9.2.1.4.5 “Medical economic standards”
  - 9.2.1.5 Episode of care
  - 9.2.1.6 Fee for service
  - 9.2.1.7 Combination of the above [please, specify]
  - 9.2.1.8 Other [please, specify]
- 9.2.2 Reimbursement to the MC Plan through a prime contractor/fund-holder with the fund-holding functions performed by:
  - 9.2.2.1 General physician practice
  - 9.2.2.2 Polyclinic
  - 9.2.2.3 Hospital
  - 9.2.2.4 Other [please, specify]
- 9.2.3 Other [please, specify]
- 9.3 Which features apply to the capitation rules and techniques? Please, indicate “yes” or “no”, and specify as appropriate.
  - 9.3.1 Capitation is comprehensive
  - 9.3.2 Capitation is partial, i.g. for out- or inpatient care, or otherwise defined service packages
  - 9.3.3 Principles of rating:
    - 9.3.3.1 Community
    - 9.3.3.2 Experience
    - 9.3.3.3 Mixed
  - 9.3.4 Cost estimations are tied to:
    - 9.3.4.1 Prior costs and utilization
    - 9.3.4.2 Prior costs, adjusted utilization
    - 9.3.4.3 Adjusted costs and utilization
  - 9.3.5 Rate is loaded with:

- 9.3.5.1 Administrative overhead
- 9.3.5.2 Reinsurance
- 9.3.5.3 Coordination of benefits
- 9.3.5.4 Net revenue margin
- 9.3.5.5 Other

9.3.6 Uniform or multi-tier [please, describe the profile of each tier, including its deviation from the average rate]

9.3.7 Term [please, indicate the time period for which capitation rate is set]

9.3.8 Interim adjustments [please, indicate controlled factor(s) and regularity, e.g. *for inflation, quarterly*]

9.3.9 Prospectively paid:

- 9.3.9.1 Installment intervals
- 9.3.9.2 Percent withheld

## 10 LEGAL AND CONTRACTUAL FRAMEWORK

10.1 Please evaluate the work done on legal and contractual aspects of the MC Plan development, adhering to the following point scale: (1) unaddressed; (2) upgraded, based on local effective bylaws or drafts as prototypes; (3) originally drafted under the ZRP effort; (4) adjusted to domestic legislation; (5) approved in draft on the executive level; (6) officially adopted; (7) took effect; (8) existing and effective prior to ZRP; (9) Other [please explain]. More than one option may be used.

- 10.1.1 Enabling statutes
- 10.1.2 Contract(s) with payer(s)
- 10.1.3 Contracts with participating providers
- 10.1.4 Membership agreement
- 10.1.5 The MC Plan Charter and Incorporating Agreement
- 10.1.6 Other [please, indicate]

## 11 INTERNAL OPERATIONS

11.1 Where does the MC Plan stand with the development of basic internal rules and procedures? Please assess using the point scale as in *Module 10*.

- 11.1.1 General outline of the MC Plan management and administration
- 11.1.2 Governing Board rules and regulations
- 11.1.3 Functions and duties of Executive Directors
- 11.1.4 Consumer grievance procedures
- 11.1.5 Other [please, specify]

## 12 CLINICAL PLAN

12.1 Using the point scale as in *Module 10*, evaluate progress with the clinical aspects of the MC Plan design, development and operations:

- 12.1.1 Mission, health goals and objectives
- 12.1.2 Itemized list of services
- 12.1.3 List of participating providers
- 12.1.4 Clinical standards/protocols
- 12.1.5 Utilization patterns, targets, and control mechanisms
- 12.1.6 Quality standards and assurance mechanisms
- 12.1.7 Other [please, specify]

### 13 **FINANCIAL AND BUSINESS PLAN**

13.1 Using the point scale as in *Module 10*, evaluate how far the MC Plan design, development and operation advanced as regards financial and business plan:

- 13.1.1 Rate-setting
  - 13.1.1.1 Capitation rate
  - 13.1.1.2 Unit costs
  - 13.1.1.3 Loading factors
  - 13.1.1.4 Charge rates
  - 13.1.1.5 Tiers
- 13.1.2 Enrollment
- 13.1.3 Volume of services
- 13.1.4 Negotiations over rates and volumes:
  - 13.1.4.1 With payers
  - 13.1.4.2 With participating providers
- 13.1.5 Other

### 14 **MANAGEMENT INFORMATION SUPPORT**

14.1 Using the point scale as in *Module 10*, evaluate progress with MIS-related activities:

- 14.1.1 Cost accounting and financial management module
- 14.1.2 Member and patient registration module
- 14.1.3 Billing and collection systems
- 14.1.4 Utilization control module
- 14.1.5 Other [please, specify]

## 15 **MARKETING AND PUBLIC RELATIONS**

15.1 Using the point scale as in *Module 10*, evaluate progress with marketing and public relations activities, that underlie the MC plan development and implementation:

15.1.1 Lobbying at the regulatory agencies

15.1.2 Persuading the payer(s)

15.1.3 Selling to the employers

15.1.4 Campaigning in the media

15.1.5 Other [please, describe]

## 16 **TRAINING AND LEARNING**

16.1 What were the main training activities and formats employed by *ZdravReform* to elaborate on managed care issues? Please assess on the following point scale: (1) not part of *ZdravReform* experience; (2) of minor relevance; (3) contributed in a visible way; (4) provided major contribution to the MC Plan design, development and/or implementation.

16.1.1 Observation tours

16.1.2 Lecturing-oriented training courses and seminars

16.1.3 Interactive workshops

16.1.4 *ZdravReform*-published and/or disseminated materials

16.1.5 On-the-job tutoring by resident advisers and visiting consultants

16.1.6 Other [please, specify]

16.2 What were the prime subject areas and targeted audiences in *ZdravReform* training activities related to managed care issues? Please use the following point scale: (1) covered on a minor level (e.g. as a side line in a much broader context); (2) covered substantially; (3) main focus; to indicate degree of coverage, where applicable, in the following matrix:

	<i>Legisla- ture, Govern- ment</i>	<i>Health sector adminis- -tration</i>	<i>MHI Fund</i>	<i>Chief hospital doctors</i>	<i>Chief polyclinic doctors</i>	<i>Physicians and health professionals</i>	<i>Employ- ers</i>	<i>Consu- -mers</i>
MC legal and contractual framework								
MC internal management rules and procedures								
MC-related benefit packages								
Utilization control and management								
Quality assurance from a perspective of MC								
Cost-conscious drug procurement and utilization								
MC-related methods of payment								
MC-related costing and budgeting								
Business plan for an MC Plan								
Management information support								
Marketing and public relations								
In aggregate								

- 16.3 How much did the local parties gain in their understanding of the basics and specifics of managed care by cooperating with *ZdravReform*? Please estimate on the following scale: (1) remained uninvolved; (2) initial knowledge was near zero and remained there; (3) knowledge was built from near zero up to conceptual understanding; (4) knowledge progressed from near zero up to design and implementation skills; (5) knowledge made headway from near zero up to operational skills; (6) substantial knowledge of the concepts was present from the outset and remained unchanged; (7) initially present

substantial knowledge of the concepts progressed to design and implementation skills; (8) initially present substantial knowledge of the concepts advanced to operational skills; (9) substantial design/implementation skills were initially present and remained unchanged; (10) substantial design/implementation skills were upgraded to hands-on operational skills; (11) ready-made managers could practice and refine their skills while cooperating with *ZdravReform*; (12) not applicable (NA).

	<i>Legisla- ture, Govern- ment</i>	<i>Health sector adminis- tration</i>	<i>MHI Fund</i>	<i>Hospital Chief Doctors</i>	<i>Polyclinic Chief Doctors</i>	<i>Physicians and health professionals</i>	<i>Employ- ers</i>	<i>Consu- mers</i>
MC legal and contractual framework								
MC internal management rules and procedures								
MC-related benefit packages								
Utilization control and management								
Quality assurance from a perspective of MC								
Cost-conscious drug procurement and utilization								
MC-related methods of payment								
MC-related costing and budgeting								
Business plan for an MC Plan								
Management information support								
Marketing and public relations								
In aggregate								

- 16.4 By way of summarizing *ZdravReform* cross-cultural experiences with managed care design and implementation: to what extent are US models applicable to the NIS settings? Please rate your judgment on the following point scale: (1) Not sure; (2) Not applicable at all; (3) Applicability does not go beyond general idea

and a few most basic concepts; (4) Adjustments are required but within reason; (5) Predominantly transferable.

	Counterparts			ZdravReform	
	<i>Regulators</i>	<i>Payers</i>	<i>Providers</i>	<i>Resident Advisers</i>	<i>Visiting Consultants</i>
MC legal and contractual framework					
MC internal management rules and procedures					
MC-related benefit packages					
Utilization control and management					
Quality assurance from a perspective of MC					
Cost-conscious drug procurement and utilization					
MC-related methods of payment					
MC-related costing and budgeting					
Business plan for an MC Plan					
Management information support					
Marketing and public relations					
In aggregate					

## 17 CASE OUTCOMES

- 17.1 What measurable changes has managed care already induced in the performance of the pilot health care facility/network, and what other changes are expected or unlikely to occur? Please, place your answers in the following table by marking the appropriate cells and inserting reported or projected statistical indicators. Provide narrative as necessary.

	<i>Reported or observed changes</i>	<i>Expected changes</i>	<i>Changes unlikely to happen</i>
Decline in hospital admission rate			
Decline in hospital length of stay			
Emergence of nursing care			
Growth in outpatient surgical activity			
Emergence of family practices			
Change in the total number of outpatient physician visits per enrollee			
Fewer referrals to specialists: number per enrollee, or percent of the total outpatient physician visits			
Development of outreach care			
Growing role of outpatient nurse practitioners			
Introduction of drug formularies to improve management of pharmaceutical supply and costs			
Changes in technical quality of care			
Improvements in perceived quality of care			
Other [please specify]			

17.2 How would you estimate the overall change in the counterparts' attitudes towards managed care?

17.2.1 In terms of how good or bad managed care is in principle:

17.2.1.1 Became fervent and unconditional advocates of managed care;

17.2.1.2 Attitudes towards managed care may vary in degree. Please use the following point scale: (4) strongly believe that this is a strength of managed care, (3) doubt that managed care promises this; (2) confident that this may not be expected from managed care; (1) not sure.

17.2.1.2.1 Improved health outcomes

17.2.1.2.2 Improved cost efficiency for the health care system at large

- 17.2.1.2.3 The opportunity for payors to shift risks onto providers
- 17.2.1.2.4 Economic autonomy for providers
- 17.2.1.2.5 Professional autonomy for providers
- 17.2.1.2.6 The opportunity for providers to earn more
- 17.2.1.2.7 The opportunity for providers to do more for their patients, in particular as far as preventive care is concerned
- 17.2.1.2.8 The opportunity for providers to be creative and grow professionally
- 17.2.1.2.9 Improved continuity of care
- 17.2.1.2.10 Improved quality of care
- 17.2.1.2.11 Improved consumer choice
- 17.2.1.2.12 Other [please specify]

#### 17.2.1.3 Became totally dissatisfied

- 17.2.2 In terms of applicability of managed care to NIS settings [please use the following point scale: (4) respective outcome is quite achievable; (3) may be achieved under certain assumptions and/or will require substantial effort; (2) may not be achieved in the foreseeable future; (1) not sure.

- 17.2.2.1 Improved health outcomes
- 17.2.2.2 Improved cost efficiency for the health care system at large
- 17.2.2.3 The opportunity for payors to shift risks onto providers
- 17.2.2.4 Economic autonomy for providers
- 17.2.2.5 Professional autonomy for providers
- 17.2.2.6 The opportunity for providers to earn more
- 17.2.2.7 The opportunity for providers to do more for their patients, in particular as far as preventive care is concerned
- 17.2.2.8 The opportunity for providers to be creative and grow professionally
- 17.2.2.9 Improved continuity of care
- 17.2.2.10 Improved quality of care
- 17.2.2.11 Improved consumer choice
- 17.2.2.12 Other [please specify]

- 17.3 As demonstrated by *ZdravReform*-supported innovation, what are the main impediments to the proliferation of managed care in NIS health care systems? Please, use the following point scale: (5) strongly agree; (4) somewhat agree; (3) rather disagree; (2) strongly disagree; (1) irrelevant; (0) not sure.

#### 17.3.1 Lack of political guidance and support from the governments

- 17.3.2 Lack and unpredictability of funding disrupts consistent implementation of any health care financing and delivery innovation
- 17.3.3 Health authorities block any innovation that may lead to broader autonomy or providers in fear that their powers will erode in a more self-regulated setting
- 17.3.4 Lack of technical experience among health system administrators, that is, they would not mind the innovation, yet do not know how to handle it)
- 17.3.5 Lack of managerial experience among chief physicians
- 17.3.6 Apprehension of managed care among providers who may be phased out of the system as the redundant or inefficient
- 17.3.7 Lack of clinical training, disallowing doctors to operate under managed care incentives and regulations (e.g., emphasis on family practice; outpatient surgery)
- 17.3.8 Opposition or lack of support for the part of employers
- 17.3.9 Opposition or lack of support for the part of population
- 17.3.10 Other [please specify]

## 18 CASE SOURCES

- 18.1.1 Please, list all the sources of information, that exist in written, video, electronic, or other formats and shed light on the case activities, status, and prospects. Under each source, please, indicate the code numbers, as specified in the squares of the following table, in order to highlight the main subjects covered by each source. More precise references (e.g. page numbers) will be greatly appreciated too. In each column-wide category both US and NIS-produced sources and their authors should be indicated under respective sub-headings, unless otherwise implied by the column title:

	<i>ZRP Publications and Reports</i>	<i>Presentation materials (sets of overheads, abstracts, etc.)</i>	<i>Academic/ professional papers</i>	<i>Domestic statutes, bylaws, regulations</i>	<i>Media articles, interviews, discussions</i>
MC legal and contractual framework	<i>1.1</i>	<i>2.1</i>	<i>3.1</i>	<i>4.1</i>	<i>5.1</i>
MC internal management rules and procedures	<i>1.2</i>	<i>2.2</i>	<i>3.2</i>	<i>4.2</i>	<i>5.2</i>
MC-related benefit packages	<i>1.3</i>	<i>2.3</i>	<i>3.3</i>	<i>4.3</i>	<i>5.3</i>
Utilization control and management	<i>1.4</i>	<i>2.4</i>	<i>3.4</i>	<i>4.4</i>	<i>5.4</i>
Quality assurance from a perspective of MC	<i>1.5</i>	<i>2.5</i>	<i>3.5</i>	<i>4.5</i>	<i>5.5</i>
Cost-conscious drug procurement and utilization	<i>1.6</i>	<i>2.6</i>	<i>3.6</i>	<i>4.6</i>	<i>5.6</i>
MC-related methods of payment	<i>1.7</i>	<i>2.7</i>	<i>3.7</i>	<i>4.7</i>	<i>5.7</i>
MC-related costing and budgeting	<i>1.8</i>	<i>2.8</i>	<i>3.8</i>	<i>4.8</i>	<i>5.8</i>
Business plan for an MC Plan	<i>1.9</i>	<i>2.9</i>	<i>3.9</i>	<i>4.9</i>	<i>5.9</i>
Management information support	<i>1.10</i>	<i>2.10</i>	<i>3.10</i>	<i>4.10</i>	<i>5.10</i>
Marketing and public relations	<i>1.11</i>	<i>2.11</i>	<i>3.11</i>	<i>4.11</i>	<i>5.11</i>
Case in general	<i>1.12</i>	<i>2.12</i>	<i>3.12</i>	<i>4.12</i>	<i>5.12</i>